

The preparation used by Shield *et al* had the same concentration of anticryptosporidial titres as preparations used and reported by other authors.^{1,4} As the patient died six months after completing the treatment I believe it would be speculative to state that permanent clearance of cryptosporidia had occurred; significant reinfection may have been detected at some point in the future had the patient survived. It was not clear whether serum immunoglobulins had been abnormal during the course of the study and neither whether human serum immunoglobulin had been administered at any point; these are factors which may have had bearing on the clinical course.

It has been observed that colostrum contains significant concentrations of non-antibody immunologically active compounds including glycoconjugates that may have activity against cryptosporidia.⁶ The pathophysiology of cryptosporidiosis is unclear and lack of effective mucosal antibody may be only one part of a complex disease process. This may be why diverse approaches to enteral immunotherapy have all shown promise. There are no data available so far to confirm that one preparation is superior to another in the management of cryptosporidiosis affecting immune deficient patients and I believe that continued single case reports will not clarify the situation. Controlled trials may enable comparisons to be made between different enteral preparations not only in terms of effectiveness but also cost, palatability, dosage, and duration of treatment.

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Inappropriate prescribing of promethazine in infants

EDITOR,—Several publications have indicated a possible link between phenothiazine administration and some cases of sudden infant death syndrome (SIDS).¹⁻³ Prompted by the observation that four of seven infants presenting to one Belgian hospital with SIDS had received trimeprazine in the days before death,¹ Kahn and Blum prospectively studied 52 SIDS victims, 36 near miss infants, and 175 controls and found 23% of SIDS victims, 22% of near miss infants, and 2% of controls were taking a phenothiazine preparation (with the same proportion of infants in each group suffering from nasopharyngitis).² Furthermore, the same group investigated the influence of phenothiazines on cardiorespiratory

and sleep characteristics in four normal infants.³ In these infants recordings showed an increase of 39% in the number of central apnoeas and short lived obstructive apnoeas on the second night of promethazine administration. These authors suggest that phenothiazines may cause central and obstructive apnoea in infants and reduced arousal and recommend that all central nervous system depressants are avoided in children under 1 year. Alternative mechanisms for phenothiazine induced apnoea have been suggested including an increase in endogenous opioid activity and an alteration in temperature regulation.^{4,5} Reviewing these studies Cantu felt that the data linking phenothiazines and SIDS was inconclusive but advised caution in the use of this class of drugs in infants less than 1 year in view of the risk of central nervous system depression and apnoea.⁶

We are concerned that promethazine is frequently prescribed for children under 2 years despite recommendations to the contrary. On reviewing the notes of the 93 consecutive children under 2 years attending casualty at Birmingham Children's Hospital with respiratory symptoms during the week before Christmas 1992, we found that 10% (six of 59 infants) of those under 1 year and 3% (one of 34 children) of those between 1 and 2 years were taking promethazine.

The manufacturers data sheet for promethazine hydrochloride (Phenergan, Rhône-Poulenc Rorer) states 'not recommended' in children less than 1 year and 'use as recommended by a doctor' in children from 1-2 years. We recognise the ambiguity of data sheet entries for many drugs used in childhood with respect to product licences and are aware that more than 25% of all drugs used at Birmingham Children's Hospital for accepted clinical indications are used outside of assumed product licence regulations (personal communication). However, the potential risks of administration of promethazine to infants outweigh any possible therapeutic benefit and we therefore urge doctors, pharmacists, and parents to avoid its use in infancy.

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Child resistant packaging and accidental child poisoning

EDITOR,—The introduction of child resistant closures for children's aspirin and paracetamol preparations in the UK in 1976 led to a significant fall in the numbers of children admitted to hospital for accidental aspirin and paracetamol poisoning.¹ The Pharmaceutical Society has since recommended that liquid methadone and all solid dose formulations are

issued in bottles with child resistant closures (R Odds, personal communication).

We are carrying out a population based study of children attending accident and emergency departments as a result of injuries and poisoning in a district in south London. On the 73 days studied over a one year period, there were three children between 2 and 3 years of age who presented after paracetamol ingestion. They had all taken liquid paracetamol, dispensed on prescription, in containers without child resistant closures.

Proprietary brands of paracetamol elixir are supplied with child resistant closures but hospital and private pharmacies dispense prescriptions of generic paracetamol elixir in bottles with plain tops. The reason given for this practice is that a standard child resistant closure design for use with the bottles used by pharmacists for liquid prescriptions has not yet been finalised and made generally available.

Although the number of children reported here is too small to allow the calculation of risk in a population, they did account for nearly 10% of all accidental ingestions in this sample. This suggests that there may be a significant number of children at risk from an easily avoidable hazard. The Department of Health should be encouraged to ensure that adequate supplies of child resistant closures are produced and that their use for children's liquid formulations is recommended. Payment for dispensing should include reimbursement of any extra cost involved in using these lids.

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Nasal instillation of 'Olbas Oil' in an infant

EDITOR,—Proprietary formulations of essential oils are readily available to the public for inhalation and are enjoying an increased popularity as natural remedies. Their toxicity when taken inappropriately by ingestion, ocular or nasal instillation is not generally appreciated. We report a case of nasal instillation.

Case history

A 4 month old boy had had four days of upper respiratory tract symptoms affecting feeding, and a relative had given his mother, a 30 year old woman with three other children, some 'Olbas Oil' without the box or instructions. She did not notice the warning against use in infants and put several drops in his right nostril. He immediately coughed, became tachypnoeic, and his colour deteriorated. An ambulance was summoned and he was brought into casualty.

On arrival he was peripherally cold with